CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/05/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155148		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/16/2011			
NAME OF PROVIDER OR SUPPLIER NORTH PARK NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 650 FAIRWAY DR EVANSVILLE, IN47710				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K0000	and State Licenconducted by the Department of accordance with Survey Date: In Facility Number Provider Number AIM Number: In Surveyor: Lexibode Specialist At this Life Safe North Park Number Found not in conduction of the National Fire and the National Fire Association (NFC Code (LSC), Challength Care Octation (NFC Code (LSC)), Challength Car	th 42 CFR 483.70(a). 1/16/11 r: 000069 er: 155148 100288980 Brashear, Life Safety ety Code survey, sing Center was empliance with for Participation in caid, 42 CFR 0(a), Life Safety the 2000 edition of re Protection FPA) 101, Life Safety apter 19, Existing cupancies and 410	K	0000	The creation and submathis plan of correcction constitute an admission provider of any conclus forth in the statement of deficiencies, or of any regulation. This provide respectfully requests the 2567 plan of correction considered the letter of allegation.	does not n by this sion set of violation of at the be	
LABORATOR		/IDED/CIIDDI IED DEDDECENITATIVE'C CI			TITI E		(V6) DATE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

000069

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155148	(X2) MULTIPLE CO A. BUILDING D. WING	NSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/16/2011		
NAME OF PROVIDER OR SUPPLIER NORTH PARK NURSING CENTER			B. WING THIS/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 650 FAIRWAY DR EVANSVILLE, IN47710				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE		
K0020 SS=E	a fire alarm syst detection in the spaces open to facility has a call had a census of this survey. Quality Review by I Code Specialist-Med The facility was compliance with aforementioned requirements a following: Stairways, elevators shafts, chutes, and between floors are having a fire resist hour. An atrium mowith 8.2.5.6. 19. Based on observinterview, the finensure 1 of 1 do openings between provided with a to prove at least	the corridors. The apacity of 103 and f 91 at the time of Robert Booher, Life Safety dical Surveyor on 11/21/11. If found not in h the diregulatory is evidenced by the ar shafts, light and ventilation dother vertical openings is enclosed with construction ance rating of at least one may be used in accordance 3.1.1. Invation and accility failed to doors in vertical in the enclose of the enclose was a manufacturer's tag is a one hour fire ing. This deficient affect up to 24 is a staff and	K0020	K 0020Corrective action that be accomplished for those residents found to have been affected by the deficient practice. The door to the basement on F Hall will be replaced with a one hour fire rating and with a fire rating ta attached. Residents identified having potential to be affecte the same deficient practice a corrective action taken: The residents on F hall have the potential to be affected. Meas	ag d ed by		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 01 A. BUILDING 155148 11/16/2011 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 650 FAIRWAY DR NORTH PARK NURSING CENTER EVANSVILLE, IN47710 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5)PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE put into place or systemic Findings include: changes made to ensure deficient practice does not recur: A one Based on observation on hour fire rated door with a fire 11/16/11 at 12:00 p.m. during a rated tag has been ordered and will be installed by tour of the facility with the 12/16/11.Administrator and Maintenance Supervisor and the Maintenance Director have Housekeeping/Laundry visually inspected the doors that Supervisor, the door to the require fire rating tags to ensure compliance monthly. Corrective basement in the F Hall was not actions will be monitored to provided with fire rating tag. This ensure the deficient practice will was confirmed by the Maintenance recur:Administrator/Maintenance Supervisor and the Supervisor will visually inspect fire Housekeeping/Laundry Supervisor rating door tags on all doors that at the time of observation. are required to have fire rating tags monthly. 3.1-19(b)There is a written plan for the protection of all K0048 patients and for their evacuation in the event SS=F of an emergency. 19.7.1.1 K0048Corrective action that will K0048 12/01/2011 Based on record review and be accomplished for those interview, the facility failed to residents found to have been provide a complete written fire affected by the deficient safety plan for the protection of practice:*The Disaster Plan has been updated to include the use 91 of 91 residents in the event of of the ABC type fire extinguishers an emergency addressing all items and the K class fire extinguisher required by NFPA 101, 2000 that is located in the edition, Section 19.7.2.2. LSC kitchen. Residents identified having potential to be affected by 19.7.2.2 requires a written health the same deficient practice and care occupancy fire safety plan corrective action taken: *All that shall provide for the residents have the potential to be affected. Measures put into place following: or systemic changes made to (1) Use of alarms ensure deficient practice does not (2) Transmission of alarm to the

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Event ID:

BQGX21

Facility ID:

000069

If continuation sheet

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AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155148		LDING	ONSTRUCTION 01	(X3) DATE COMPL 11/16/2	ETED
NAME OF PROVIDER OR SUPPLIER NORTH PARK NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 650 FAIRWAY DR EVANSVILLE, IN47710				
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	(6) Evacuation compartment (7) Preparation building for ev (8) Extinguishr This deficient pall occupants i emergency. Findings included Based on a reverse written fire saft Disaster Manual 11:15 a.m. with Supervisor and Housekeeping, present, the fire not address the type fire extinguishing the kitchen in use of the kitchen in	o alarms fire of immediate area of smoke of floors and acuation nent of fire oractice could affect in the event of an de: iew of the facility's ety plan in the al on 11/16/11 at the Maintenance the /Laundry Supervisor re safety plan did e use of the ABC guishers located e building or the K guisher located in relationship with the hen overhead system. Based on the time of record intenance			recur:*The Dietary staff was inserviced on 11/30/11 by th administrator on the activation the overhead hood extinguish system to suppress a fire becausing the K class fire extinguisher.*The Disaster F was updated to include the update the ABC type fire extinguisher and the K class fire extinguisher and the K class fire extinguish that is located in the kitchen. Disaster Manual will be reviet quarterly for any needed changes. Corrective actions to be monitored to ensure the deficient practice will not recur:*The Administrator/designee will represent the CQI team.	on of hing fore Plan use of ers sher *The ewed will eview und	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155148	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/16/2011		
NAME OF PROVIDER OR SUPPLIER NORTH PARK NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 650 FAIRWAY DR EVANSVILLE, IN47710				
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K0052 SS=F	of the ABC type or the kitchen is activate the over extinguishing is a fire before us extinguisher. 3.1–19(b) A fire alarm syster installed, tested, a accordance with N Code and NFPA 7 approved mainten complying with app NFPA 70 and 72. Based on recordinterview, the frensure document testing of all smooth correct. LSC 9. NFPA 72, Nation Code. NFPA 72 fire alarm system smoke detector annually. This could affect all as staff and visit of the country included the coun	inot include the use a fire extinguishers staff training to be a ferhead hood system to suppress ing the K class fire. In required for life safety is and maintained in IFPA 70 National Electrical 2. The system has an ance and testing program plicable requirements of 9.6.1.4 dreview and accility failed to entation for the moke detectors was 6.1.4 refers to nal Fire Alarm 2, 7–3.2 requires and devices such as res be tested deficient practice residents, as well itors in the facility.	K0052	K0052Corrective action that to be accomplished for those residents found to have been affected by the deficient practice:Administrator and licensed contractor have visu inventoried all smoke detected and documented that inventoried location. Residents identified having potential to be affected the same deficient practice a corrective action taken: All residents have the potential that affected. Measures put into ploor systemic changes made to ensure deficient practice does recur: Administrator and licent contractor have done a visual inventory of all smoke detection 11/29/11 and 11/30/11. *A	ally pors pory by ad by and alloce por so so not ansed allocres.		

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Event ID:

BQGX21 Facility ID:

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155148		LDING	01	COMPLETED 11/16/2011	
		100140	B. WIN			11/10/2011	
NAME OF P	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
N∩DT⊔ !	PARK NURSING CE	-NTFR			RWAY DR VILLE, IN47710		
				<u> </u>	VILLE, 118711 IU	~	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	TE DATE	
	semiannual fire		$\neg \vdash$		complete system retest will b		
	inspection repo	•			performed on 12/05/11 by	_	
	1	aintenance book on			licensed contractor.Correctiv actions will be monitored to	e	
		0:30 a.m. with the			ensure the deficient practice	will	
		upervisor and the			not recur:*All inspections and	d	
ļ		Laundry Supervisor			testing done by outside contr		
ļ	present, the tw				will be monitored by Mainten Supervisor/designee.*Inspec		
	semiannual fire				and testing documentation w		
ļ	inspection repo				reviewed for accuracy by the		
	1	10/25/11 were not			administrator after each		
		he correct number			inspection by the outside contractor.*The		
ļ		ctors provided in			administrator/designee will re	eview	
ļ		he cover page on			audits in quarterly CQI meeti		
ļ	_	sted forty eight total					
ļ	smoke detector	· -					
ļ		moke detectors and					
ļ		ectors), however,					
ļ	the itemized lis						
ļ							
ļ	detectors in each	•					
ļ	forty two smok						
ļ		fying the type of					
ļ		r) and thirteen Duct					
ļ		a total of fifty five					
ļ	smoke detector	• •					
ļ		nsitivity test report					
		0 indicated only					
	fifty total smoke detectors were tested. During an interview at the time of record review, the Maintenance Supervisor and the Housekeeping/Laundry Supervisor acknowledged the number of						
ļ							
<u></u>	smoke detector	rs listed on the					
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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155148	(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION 01	(X3) DATE COMP. 11/16/2	
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	cover pages, se system reports	emiannual fire alarm , and the most ty test report were		CROSS-REFERENCED TO THE APPROPRIATE	RIATE	